

## PLAYER MEDICAL INFORMATION SHEET

Name: \_\_\_\_\_

Date of birth: Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

Address: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Telephone: \_\_\_\_\_

*Person to contact in case of accident or emergency.*

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Care Card No. \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

*Please circle the appropriate response below pertaining to you.*

- |     |    |  |
|-----|----|--|
| Yes | No | Previous history of concussions                              |
| Yes | No | Fainting episodes during exercise                            |
| Yes | No | Epileptic  |
| Yes | No | Wears glasses  |
| Yes | No | Are lenses shatterproof?                                     |
| Yes | No | Wears contact lenses   |
| Yes | No | Wears dental appliance                                       |
| Yes | No | Hearing problem  |
| Yes | No | Asthma   |
| Yes | No | Trouble breathing during exercise                            |
| Yes | No | Heart Condition  |
| Yes | No | Diabetic   |
| Yes | No | Has had an illness lasting more than a week in the past year |

Name: \_\_\_\_\_

- Yes No Medication
- Yes No Allergies
- Yes No Wears a medic alert bracelet or necklace.
- Yes No Do you have any health problem that would interfere with participation on a hockey team?
- Yes No Surgery in the last year.
- Yes No Have been in hospital in the last year.
- Yes No Has had injuries requiring medical attention in the past year.
- Yes No Presently injured.

*Please give details below if you answered "Yes" to any of the above items.*  
(Use separate sheet if necessary)

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Medications: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medical conditions: \_\_\_\_\_

Recent Injuries: \_\_\_\_\_

Last Tetanus Shot: \_\_\_\_\_

Any information not covered above: \_\_\_\_\_

Date of last complete physical examination: \_\_\_\_\_

**\* Any medical condition or injury problem should be checked by your physician before participating in a hockey program.**

I understand that it is my responsibility to keep the team management advised of any change in the above information as soon as possible and that in the event no one can be contacted, team management will take me to hospital/M.D. if deemed necessary.

I hereby authorize the physician and nursing staff to undertake examination investigation and necessary treatment of myself.

I also authorize release of information to appropriate people (coach, physician) as deemed necessary.

**Date:** \_\_\_\_\_ **Signature:** \_\_\_\_\_